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COST CONTAINMENT POSSIBILITIES IN LABOR-MANAGEMENT HEALTH PLANS

[by Bruce Fayer]

Continued inflation of health care costs is forcing many difficult choices in collective bargaining in California. Money otherwise available for wage increases is being allocated instead to health plans. But needed improvements in health benefits are not then forthcoming; the previous level of health benefits and services may be maintained in the negotiating process, or it may be reduced.

What are the major areas and possibilities for cost control in labor-management plans? What options are available to California unions and health plan trustees and administrators and consultants, to protect their programs from the pressures of continued health care cost inflation, and to protect (if not to expand) existing benefit levels?

In government health programs, which confront the same inflationary pressures, there have been significant efforts to control cost allocations--but not necessarily to protect benefit levels. Unfortunately, the cost control efforts of both the California legislature and the Reagan Administration can be expected to result in even greater cost pressures on the labor-management plans--especially the Administration's current effort to tax employee contributions to health plans (see LCR 91 and 93, May and June 1983). As a result of these combined pressures, employers throughout California have formed health care cost containment coalitions, and many new consulting firms have appeared on the scene, to analyze, educate, and recommend cost control solutions.

Some Unions Have More Protection than Others -- One option utilized by many California unions has permitted greater cost control and often better quality of care in negotiated plans. That is the increasing use of Health Maintenance Organizations, which now enroll about 20% of California's union members and their dependents. However, there are reports from many unions of over-enrollment in HMOs, resulting in complaints about services. Further, the financing assistance to stimulate the development of more HMOs is not available from the Reagan Administration. What has been an HMO safety valve for many unions for at least the past five years is thus being closed off.

A second observable trend in recent years, of equal significance in controlling health care costs, has been a shift to self-insurance in many negotiated plans. National data indicates that annual costs of administering insured health plans are extremely high--between 12% and 15% of total premiums over the past decade. Of great significance in these costs are the familiar "retentions" of the commercial insurance carriers--plus the enormous fees paid to consultants and others (who have failed in the past to exercise even minimal control over administrative costs). A few self-insured labor-management health plans in California have not only achieved significant savings in the costs of administration, but have improved their data bases, and have also found themselves much freer to adopt new techniques for cost and quality control.

One new technique has recently become available, and will probably be utilized first by labor-management plans which are not only self-insured, but also in full control of their own administrative procedures. That involves negotiating directly with hospitals and possibly also with groups of "preferred providers" for pre-paid coverage for any part of the plan's population which electes such coverage. The MediCal program has led the way to this approach, with some 90% of its coverage having now been negotiated with hosptials. Most metropolitan area hospitals in California have excess bed capacity, and therefore also have the economic incentive to help develop such direct coverage.

Third, a few California labor-management plans have developed administrative procedures which have proven effective both in controlling costs and in improving the quality of care. These include:

(a) use of a systematic program to review claims, in order to monitor the "reasonableness" of both charges and medical procedures utilized;

(b) development of a complete data base to show how health benefits and services are utilized in the plan for types of services (i.e., preventive care, out-patient care, surgery, rehabilitation, etc.); for details on hospitalization (i.e., length of stay, and use of alternative convalescent or nursing home facilities); and

for groups covered (i.e., workers, dependents, retirees)--and periodic analysis of this utilization data by independent medical auditors who can report on its implications with respect to both the cost and the quality of care rendered;

(c) periodic review of the benefit structure of the plan, to determine the impact of uncovered services, and to determine whether the combination of covered and uncovered services is in the best interests of enrolled members and dependents (the combination may be devised in large part to meet the economic interests of the commercial insurance carriers, or the providers, or both).

The use of claims and utilization review systems, and also the use of utilization "control" techniques such as second and third opinions on surgery, all require precise data and careful analysis of the impact on quality of care. In these programs, an emphasis on "cost control" alone is not only insufficient, it is also dangerous, because of the potential impact on quality of care. Careful data is also the key to some more positive and active "control" approaches which emphasize health maintenance (especially those based on physical exercise or nutrition programs), or rehabilitation (especially for drug and alcohol abuse). In these programs, the data necessary to prove cost effectiveness is often missing or inconclusive; nonetheless, some programs designed to maintain or improve health have shown great promise.

Labor's Major Health Care Problem -- Although labor and management negotiators in California alone now pump more than $6 billion a year into health care packages, there is no central source of information and analysis of what is being done to control costs and quality of the health care that is purchased. There are at least 1,000 separate negotiated health plans in California (no one even knows the exact number). There is no systematic reporting of what is being tried in these plans, so there is no way to evaluate what works and what doesn't, what might improve health care, and what might be dangerous to try.

To consider these problems further, the California Labor Federation will hold a two-day conference on health care costs and benefits, at the Plaza Airport Inn, Millbrae, October 17-18. Those who are familiar with cost containment efforts in labor management plans in each of the areas outlined above will be available to discuss what has been tried, what the results have been, and what still must be done.

There will also be time at the concluding session of the CLF conference on October 18, to consider further positive steps which labor could take, not only to check cost inflation but also to improve negotiated health care. The major policy alternatives for California unions appear to be

(a) to try to negotiate $7 billion in this state next year, to cover the inflation of this year's $6 billion bill for health plan premiums; this course will not only continue inflation as usual, but threatens also to reduce other negotiated benefits, and to cut further into wages;

(b) to try to develop a more basic and a more coordinated labor program, which could take the following kinds of steps: (1) develop a statewide labor committee on negotiated health care, to provide for the funding and the hiring of a professional staff for research assistance and representation of labor's health care interests; (2) hold meetings with providers, insurers, business and employer coalitions, and government representatives, in order to define and protect labor's interests in negotiated health plans; (3) develop recommended cost, benefit, and administrative guidelines for all negotiated coverage; (4) assist representatives of negotiated plans in California to develop new options for controlling costs and improving health care, by cooperating and working together both in the negotiation and in the administration of health plans.

Taking these steps could lead in the long run to greater uniformity and better quality in negotiated health plans, and greater bargaining power with the high cost providers and their insurance agents.

-- Bruce Poyer